Catherine M. Malkin, Ph.D., LLC
7100 N. High St., Suite 205 Worthington, OH 43085
Ph: 614-505-6949 Fax: 614-505-6558
www.catherinemalkinpsychologist.com

Informed Consent for Participation in Treatment

Welcome to my practice. Please read this document carefully. It contains important information about my business, office policies, and psychological practices. If you have questions write them down and ask me at our first meeting. When you sign this form it represents an agreement between us. You will be given a copy of this form if you wish. Please initial pages 1 and 2 after you have read them, and sign on page 3.

Name of Client: _____

If applicable, Name of Parent/Legal Guardian: _____

Types of Services Provided: You/your child will be interviewed and may be asked to fill out some questionnaires to assist the therapist in understanding how to best help you. If psychological testing is recommended, this will be discussed, and I will give you names of psychologists who conduct such testing as is needed. I will gather information on your/your child's life history, your/your child's current situation, and what brings you to therapy. I will ask you to generate goals for your/your child's therapy, because this makes your/your child's therapy more effective. Treatment may be individual sessions, or sessions may include family members or significant others as part of therapy. With young children parental involvement is often an important part of therapy.

You/your child will often be given homework assignments, and therapy is less effective when the homework is not completed. We will plan the homework together in sessions and it might involve such things as practicing new ways of thinking, relaxation techniques, reading relevant material, or writing down thoughts or feelings. The duration of therapy is different for everyone and can be difficult to estimate. Throughout therapy we will continue to assess your/your child's progress towards your goals, and we will revise them together as needed. If you are dissatisfied with therapy at any time, it is important and helpful to discuss this with me so that we can address what may be impeding progress. I will make a referral to another therapist if necessary, and/or at your request. It is your right to discontinue therapy at any time. Sometimes, when beginning therapy, people experience a temporary increase in their distress because the process of addressing and clarifying personal issues can be difficult or painful. Please be aware of this, and know that it is not an uncommon part of therapy. Please ask me if you have questions about any of this.

Confidentiality: What you discuss with me is kept confidential, or private, and may not be disclosed without your written permission. However, there are several exceptions to this: if you or your child are actively suicidal or are thinking of hurting another person I am legally bound to protect you/your child and the other party. Confidentiality may therefore have to be broken. Also, if I become aware of any information that may indicate child abuse or neglect, I am a mandated reporter and by law must report this information to the proper government agency. The Notice of Privacy Practices form gives detailed information regarding the protection of your private healthcare information, and how it may be shared. I may ask you to sign release of information forms for me to communicate with other professionals (e.g., physicians, previous therapists, school counselors); you have the right to refuse to sign these forms if you so choose. If I am out of town and you would like to meet with another therapist during that time, I would have you sign a release of information form for me to give them any information necessary. If you choose to use your insurance, your insurance company may request information, and my billing company will need to provide that information to the insurance company to facilitate payment. Insurance companies require you to authorize me to provide them with a clinical diagnosis and sometimes they request additional clinical information such as treatment plans or summaries of progress, or (in rare cases) copies of the entire record.

_____Initials

Confidentiality for children and teenagers will be discussed during our first appointment, to clarify the rights and needs of children and teens in therapy, as well as their parents' rights. Confidentiality for couples and families in therapy will also be discussed at the beginning of treatment.

Professional Records: The laws and standards of my profession require that I maintain treatment records. You are entitled to receive a copy of your/your child's records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to read. If you wish to see the records, I recommend that you review them with me so that we can discuss the contents.

Release of Liability: If you/your child fails to show for an appointment, I will try to reach you during that appointment time at the telephone number you provided. If I do not hear from you within one week of that missed appointment, you have released me of liability for your psychological care. Also, if you cancel an appointment without rescheduling, you release me of liability for your psychological care. You are welcome to reschedule at any time, provided that any past balances (including missed appointment fees) are paid. If there are extenuating circumstances, such as family emergencies or sudden business trips, please contact me as soon as possible to inform me.

Fees for Services: Payment for services must be made at each session. If you use insurance, you are expected to pay any co-payment required by your insurance at your session. Should your insurance company refuse payment for the services, you will be held responsible for paying the amount in full, as allowable by contract. If you do not pay your bill within 30 days of the date of an invoice, 2% interest may be added per month on the balance. In addition, if you default on your bill you will be charged for any collection fees I may incur. Please note that there is a $25 service charge for all returned checks. I do not accept any credit cards.

As a courtesy service to you, my billing service will file claims to your insurance company, but it is your responsibility to make sure that your bill is paid in full. The billing service contact person is Annie; she can be reached at 614-270-2990. If you have questions regarding your bill or your insurance, please call Annie.

I recommend you verify with your insurance company your mental health benefits so that you know the maximum number of sessions or money you are allowed per year, as well as the amount of your deductible and copayment. For further information about using insurance, please see the form "Using insurance."

Initial appointment (60 minutes): $220	Individual therapy (38-52 minutes): $170
Half session (16-37 minutes): $98	Family, couples, or parent therapy session (38-52 minutes): $190
Assessment forms: $6 per form	Extended Session (53-60 minutes): $195

Missed appointments (without 48 hours notice): $195 (this is charged to you; insurance will not pay)
Phone calls longer than 5 minutes: $3.25 per minute (insurance will not pay)
Letters, formal reports, travel time for out-of-office services: $220 per 60 minutes (insurance will not pay)
Testifying in court, depositions, and court-related work including travel time is payable in full in advance (including if subpoenaed, even if called by another party): $350/hour (insurance will not pay)

Cancellation Policy: You will be billed the full fee ($195) if you miss an appointment without providing at least 48 hours notice. Insurance companies will not pay this fee; it is charged to you. Giving me proper notice when you cancel allows me to offer the time to another person. If you are unable to give 48 hours notice, call as soon as you can because if I can fill your appointment time I will not charge you the cancellation fee.

Contacting Dr. Malkin: I am not immediately available by telephone. While I am usually in my office Thursdays through Saturdays, I do not answer the phone while I am with someone. However, the best way to reach me is by telephone; my phone has confidential voice mail, and if you leave me a message with your name and phone number, I will return your call within one to two business days.

_____Initial

The exception to this would be if it is a holiday or I am out of town, and my voice mail message would let you know if this is the case. It is helpful if you let me know when you are likely to be available. If you are unable to reach me and it is an emergency, contact your family doctor or the nearest hospital emergency room. If I will be unavailable for an extended period of time, we will discuss what coverage options you would like, and I will give you the name of another therapist to contact if you wish.

Email is not a secure medium for communication, so I do not use email. If you choose to contact me via email, you are doing so with the full understanding that I cannot guarantee the safety and security of that communication, despite taking all possible actions to protect your privacy. Email is not checked regularly, and therefore no urgent or time-bound messages should be communicated via email. Also, if you email me, I will assume you are granting me permission to respond by email and that you understand that such communication may not be confidential or secure.

Please initial one of the statements below:

_____ I do NOT authorize release of any information about me/my child or my/my child's treatment to an insurance company. I will be responsible to pay all fees for treatment myself.

_____ I authorize Dr. Malkin to release information about me/my child as necessary to her billing service and my insurance company for billing purposes.

If you choose to use your insurance, please complete the Authorization for Signature on File form.

Please sign below to indicate that you have read and understand this Informed Consent for Participation in Treatment form, and that you consent to treatment and the provisions in this form.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Legal Guardian Date

_____

Relationship to Client

I have read and/or been given a copy of the Privacy Practices Notice:

_____

Signature of Client/Parent/Legal Guardian

Name of person who referred you: _____

May I send the referring person a thank you, if he/she is a professional? Yes: _____ No: _____

_____ _____

Catherine M. Malkin, Ph.D. Date